ILLINOIS
Foot & Ankle
CENTER
Kelly N. May, DPM, FACFAS

PATIENT REGISTRATION

Patient Name: _____ Gender: □ Male □ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____

Marital Status: □ Single □ Married □ Widowed

Preferred Phone: _____ □ Home □ Cell □ Work

Alternate Phone: _____ □ Home □ Cell □ Work

Email Address: _____

Appointment Reminders: □ Email □ Text □ Office Call □ Voice reminder

Employer: _____ Occupation: _____

Primary Doctor: _____

Emergency Contact Person: _____
Relationship: _____
Phone Number: _____

DEMOGRAPHICS

Preferred Language: □ English □ Spanish □ Polish □ Other: _____

Race: □ African American □ Asian □ Caucasian □ Hispanic/Latino □ Other: _____

HOW DID YOU HEAR ABOUT US?

□ Family/Friend: _____ □ Google/Internet □ Insurance Company
□ Doctor Referral □ Drive-by □ Other: _____

PHARMACY

Name: _____ Intersection/City: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

INSURANCE INFORMATION

If policyholder is someone other than patient

INSURANCE

Primary: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ___
Zip code: _____
Phone Number: _____
Relation to Patient: □ Spouse □ Parent □ Other

Secondary: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ____
Zip code: _____
Phone Number: _____
Relation to Patient: □ Spouse □ Parent □ Other

GUARANTOR ****Person ultimately responsible for bills****

□ Patient

□ Policyholder of insurance (above)

□ Other: Name: _____

Address: _____

City: _____ State: ____ Zip code: _____

Phone Number: _____

ILLINOIS
Foot & Ankle
CENTER
Kelly N. May, DPM, FACFAS

TREATMENT AGREEMENT

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

I hereby authorize this practice to disclose both orally and in writing all facts pertaining the the past, present, and future considerations, treatments, and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing, and changes. I understand that I may change this authorization in writing at any time. **Grab a free copy on the desk**

Please include any legal guardians. You may release to the following people:

Name	Relationship	Telephone

I acknowledge the Notice of Privacy Practices (HIPAA) and I have read (or had the opportunity to read) and understand the Notice. I understand and agree to the Treatment Agreement. I also received a copy of the Financial Agreement. I agree to the Communication agreements.

_____ _____

Patient Name (please print) Date

_____

Patient/Guardian Signature